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PARENT QUESTIONNAIRE

Child's name ____ Date of Birth _________

Form completed by: ____

Parent/Guardian Name(s) ____

Home address and phone number ____
____
____

Child is: Biological _________ Foster __________ Adopted ______ If so, at what age: _________

Handedness: Right_____ Left______ Mixed_______

Who suggested this evaluation? ____

Please describe your child's strengths ____
____
____
____
____

Please describe your child's difficulties ____
____
____
____
____

What are your main concerns that you would like addressed in the current evaluation:___________
____
____
____

What are your child's main interests: ____
____

Has your child had any previous related assessments, such as educational, PT, OT, speech, psychological, neuropsychological or psychiatric? _________ If so, please bring copies of the reports with you if possible.

FAMILY:

Whom does your child live with at present (include ages of siblings)?
____
____

Does your child have other siblings not currently in the household (if so please include ages)?
____

Mother's education:_______ Mother's occupation:_____________________________________

Father's education:________ Father's occupation:_____________________________________

Do any family members have any developmental/learning difficulties?
____
____

Do any family members have psychiatric or behavioral problems:
____
____

EDUCATION:

Child's current school: _________________________________ Child's current grade:___________

Please check for each subject that child takes: failing below average average above average

Subject	failing / below average / average / above average
Reading	________________________________
Writing/Spelling	________________________________
Arithmetic/Math	________________________________
Science	________________________________
Other _______________	________________________________
Other _______________	________________________________

What comments have teachers in the past made regarding your child's learning and behavior?
____
____

Describe your child's current educational program (e.g. public/private, size of class)
____
____

Does your child have behavioral difficulties in school?
____
____

Is your child currently receiving special services in school: yes:_________ no:_________
If yes, for how long:____________________
If yes, please describe current services:____

Has your child repeated a grade: yes:________ no:__________
If yes, when:____________

Has your child received services outside of school to address his/her learning difficulties:
Yes:___________ No:____________

If yes, please explain the dates and the nature of the service(s) (e.g. tutoring, reading assistance etc.)

Service:____from:_______ to:________

Service:____from:_______ to:________

Service:____from:_______ to:________

MEDICAL HISTORY:

How was the pregnancy, labor and delivery with this child (e.g. any complications) ?
____
____
Medications used during pregnancy:____
____
Alcohol during pregnancy:____________ Smoking during pregnancy:________________________
Drug use during pregnancy (specify type of drug and how often it was used):_________________
____
Duration of pregnancy:_____________ Apgar scores: ________________________________
Child’s birth weight and length:____

Has your child ever been hospitalized for medical reasons: yes:_________ no:____________
If yes, please describe:____
____
____
Has your child had serious illnesses or accidents? _______________________________________
Has your child ever lost consciousness for any reason: yes:_________ no:___________
If yes, please explain:____
Has your child had ear infections? _______ How many? ________ Were tubes placed? _________
Has hearing been checked? ________________ Has vision been checked? ____________________
List medications/dosages your child takes ____
____
How does your child sleep? _____________________ Eat? ________________________________
Does your child have any current medical or psychiatric diagnosis: yes:__________ no:__________
If yes, please explain:____
____
Has your child have ever been hospitalized due to behavioral/psychiatric difficulties:
yes:__________ no:__________
If yes, please explain:____
____
____

Do you have concerns about your child's physical abilities or functioning?

____

Do you have concerns about weight gain/loss or nutritional issues?

____

DEVELOPMENT:

At what age did you first become concerned about your child, and why? ______________________
____
____
____
____
____
____
____
____

Language:
At what age did your child start using single words? _________ sentences? _________________
Have you been in the past, or are you presently concerned about your child's speech and language skills (talking and understanding) ____

____

____
Has your child experienced reading difficulties? ____
If so please explain:____

Motor skills:
At what age did your child start to crawl ___________________start to walk __________________
Do you have concerns about your child's gross skills (e.g. walking, running)

____

Do you have concerns about your child's fine motor skills (using buttons, zippers, handwriting)

____

Home Behavior:
All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe you child exhibits to an excessive or exaggerated degree when compared to other children his or her age:

Hyperactivity (high activity level):	____________
Poor impulse control:	____________
Poor attention span:	____________
Low frustration threshold:	____________
Temper outbursts:	____________
Sloppy table manners:	____________
Unusually 'messy':	____________
Doesn't listen when spoken to:	____________
Physically abusive to other children:	_____________
Always 'on the go':	_____________
Wears out shoes more frequently than sibs:	_____________
Heedless to danger:	_____________
Accident prone:	_____________
Doesn't learn from experience:	_____________
Poor memory:	_____________
Difficulty adjusting to new environments:	_____________

Social-emotional:
How does your child get along with peers:
____

____

About how many close friends does your child have? ____

Are there behavior problems at home: ____
____

Are you concerned about your child's feelings and emotions (seems worried, sad etc.) ___________
____

Has your child and/or your family been in psychotherapy or counseling?______________________
____

THIS ASSESSMENT:
Please describe what you hope to learn from this assessment:

____
____
____

Other relevant information for us to know about your child:

____
____
____
____
____
____
____
____
____
____

PLEASE MAIL/FAX THIS FORM BACK PRIOR TO FIRST APPOINTMENT
Fax 510 594-2552